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**Notice of Independent Review Decision**

**DATE NOTICE SENT TO ALL PARTIES:** 3/30/15

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**
The item in dispute is the prospective medical necessity of an outpatient caudal epidural steroid injection for the lumbar spine.

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**
The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of an outpatient caudal epidural steroid injection for the lumbar spine.

**PATIENT CLINICAL HISTORY [SUMMARY]:**
This claimant has a date of birth of xx/xx/xx. On xx/xx/xx he slipped and fell on stairs resulting in back pain. He has had an L3/4 fusion on 11/21/2010. He is currently working full time without restrictions and is prescribed Zanaflex and Gabapentin for the pain. On a recent examination, the claimant is 6'5" with BMI 36.38 and there is normal strength and reflexes in the lower extremities with minimal gluteal weakness. He has also had bilateral hip surgery secondary to osteoarthritis. MRI shows multilevel lumbar spondylosis with L2/3 stenosis. indicates this is a recurrent herniation at L2/3. recommends an ESI at this level.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

This request does not meet the ODG criteria an epidural steroid injection. Although ESI is recommended for radicular pain, radiculopathy is not documented. There has been a fusion at L23. There is no EMG to support radiculopathy. The lower extremity weakness detected is of the gluteus (L5).

The guidelines do recommend ESI as a possible option for short term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis although ESIs have not been found to be as beneficial a treatment for the latter condition. The criteria include that 1. Radiculopathy must be documented objectively. 2. Condition should be initially unresponsive to conservative treatment.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**